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Editorial

Eradication of *Pseudomonas aeruginosa* by early antibiotic treatment has been one of the major advances in the last decade for subjects with CF [1]. This fantastic success has let many people to forget that this pathogen is not the only one present in CF airways. The study by Vanderhelst and colleagues [2] puts the finger on another dangerous bacterium, methicillin-resistant *Staphylococcus aureus* (MRSA) which rose in prevalence in CF from 0.1% in 1995 to 22% in 2007. Using registry data from 2002 to 2010, their retrospective case–control study showed that the prevalence of MRSA in chronically *S. aureus* infected patients, was 15.2% from which 12.6% were chronically infected. Importantly, MRSA caused a more rapid lung function decline compared with controls.

Where do these bacteria come from? What are the risk factors for MRSA acquisition? Vanderhelst and colleagues concluded that acquisition of MRSA was associated with hospitalization, the F508del genotype and the presence of bronchiectasis. Unfortunately, a molecular characterization of the MRSA strains was not anymore possible, allowing a clarification whether these MRSA strains are clonal, hospital or community acquired and positive the Panton–Valentine leukocidin or other virulence factors. Larger prospective longitudinal studies are needed to close this gap in our understanding and support the notion of the authors that MRSA is present in more severely ill patients. Until then, and based on their and other data [3], Vanderhelst and colleagues emphasize the importance of segregation, hygiene, surveillance and early eradication therapy for the management of MRSA in CF.

The article in this issue on chronic methicillin-resistant *Staphylococcus aureus* (MRSA) colonization in patients with cystic fibrosis is free to download at cysticfibrosisjournal.com.

References

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